FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034678

Facility Name: THE LINCOLN HOME

Address: 150 NORTH 27TH STREET (Number) BELLEVILLE (City) 62226 (Zip Code)

County: SINCLAIR

Telephone Number: (618) 235-6600 **Fax #** (618) 235-7555

IDPA ID Number: 37-1237031001

Date of Initial License for Current Owners: 09/88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2005 to 12/31/2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MARTIN WEISS
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK, BOKOR, KAGDA & BROOKS, LTD, 3750 W DEVON, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	62	Skilled (SNF)	62	22,630	1
2		Skilled Pediatric (SNF/PED)			2
3	90	Intermediate (ICF)	90	32,850	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	152	TOTALS	152	55,480	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,261	6,261	8
9	SNF/PED					9
10	ICF	30,830	8,147	1,418	40,395	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,830	8,147	7,679	46,656	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.10%

D. How many bed-hold days during this year were paid by the Department? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 62 and days of care provided 5,478

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2005 Fiscal Year: 12/31/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,010	21,202	12,078	230,290		230,290		230,290			1
2	Food Purchase		196,990		196,990		196,990	(188)	196,802			2
3	Housekeeping	175,514	26,368		201,882		201,882		201,882			3
4	Laundry	54,499	14,703	1,325	70,527		70,527		70,527			4
5	Heat and Other Utilities			127,248	127,248		127,248		127,248			5
6	Maintenance	78,567	45,674	12,641	136,882		136,882		136,882			6
7	Other (specify):*			6,938	6,938		6,938		6,938			7
8	**TOTAL General Services**	505,590	304,937	160,230	970,757		970,757	(188)	970,569			8
	B. Health Care and Programs											
9	Medical Director			37,000	37,000		37,000		37,000			9
10	Nursing and Medical Records	1,631,825	125,094	17,367	1,774,286		1,774,286		1,774,286			10
10a	Therapy											10a
11	Activities	66,800	5,409	3,042	75,251		75,251		75,251			11
12	Social Services	51,749	244		51,993		51,993		51,993			12
13	CNA Training											13
14	Program Transportation			2,341	2,341		2,341		2,341			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,750,374	130,747	59,750	1,940,871		1,940,871		1,940,871			16
	C. General Administration											
17	Administrative	77,268		360,000	437,268		437,268	656,695	1,093,963			17
18	Directors Fees											18
19	Professional Services			496,306	496,306		496,306	(299,010)	197,296			19
20	Dues, Fees, Subscriptions & Promotions			67,466	67,466		67,466	(22,731)	44,735			20
21	Clerical & General Office Expenses	159,557	22,433	39,219	221,209		221,209	15,774	236,983			21
22	Employee Benefits & Payroll Taxes			495,033	495,033		495,033		495,033			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,650	13,650		13,650		13,650			24
25	Other Admin. Staff Transportation			12,608	12,608		12,608		12,608			25
26	Insurance-Prop.Liab.Malpractice			156,423	156,423		156,423	965	157,388			26
27	Other (specify):*			1,904	1,904		1,904	37,777	39,681			27
28	**TOTAL General Administration**	236,825	22,433	1,642,609	1,901,867		1,901,867	389,470	2,291,337			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,492,789	458,117	1,862,589	4,813,495		4,813,495	389,282	5,202,777			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: THE LINCOLN HOME **#0034678** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,078	
	REPAIRS & MAINTENANCE		0	
			0	12,078
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,325	
			0	1,325
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		27,440	
	ELECTRICITY		60,356	
	WATER		38,793	
	CABLE TV - LOBBY		659	
			0	127,248
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,774	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		101	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		2,432	
	EXTERMINATING SERVICE		1,400	
	FIRE SERVICE		2,934	
			0	
			0	
			0	12,641
7	**OTHER**			
	SCAVENGER		6,938	
	SECURITY SERVICE		0	6,938
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	37,000	37,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,500	
	PHARMACY CONSULTANT	XVIII B 39-2	2,736	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	10,131	
			0	
			0	17,367
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	3,042	
			0	3,042
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE LINCOLN HOME **#0034678** **Report Period Beginning: 01/01/2005** **Ending: 12/31/2005**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		2,341	2,341
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	360,000	360,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,035	
	BOOKKEEPING/ADMINISTRATIVE SERVICE	XIX C	300,000	
	PROFESSIONAL FEES	XIX C	191,271	
			0	496,306
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	20,790	
	EMPLOYEE WANT ADS	XIX F	33,867	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	6,531	
	LICENSES & PERMITS	XIX F	1,330	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F		
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,578	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,370	67,466
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		497	
	EQUIPMENT REPAIR & MAINTENANCE		12,543	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,991	
	MESSENGER SERVICE		3,188	
			0	39,219

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	189,970	
	UNEMPLOYMENT COMPENSATION	XIX D	82,233	
	WORKERS COMPENSATION INSURANCI	XIX D	99,201	
	HOSPITALIZATION INSURANCE	XIX D	116,683	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,946	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	495,033
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	3,556	
	TRAVEL	XIX G	10,094	
			0	
			0	13,650
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,608	12,608
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		156,423	156,423
27	**OTHER**			
	BAD DEBTS	VI 24	1,904	
				1,904

GRAND TOTAL COLUMN 3 OTHER 1,862,589

THE LINCOLN HOME
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2005

TOTAL FOOD PURCHASE	196,990	PATIENT MEALS	139968
LESS SALES TAX	(188)	ADD EMPLOYEE MEALS	0
NET FOOD	196,802	TOTAL MEALS/YEAR	139968
TOTAL PATIENT CENSUS	46,656	NET FOOD	196802
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	139968
TOTAL PATIENT MEALS	139968	COST PER MEAL	1.41
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number THE LINCOLN HOME #0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			26,115	26,115		26,115	209,686	235,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,299	1,299		1,299	231,357	232,656			32
33	Real Estate Taxes			46,201	46,201		46,201		46,201			33
34	Rent-Facility & Grounds			450,000	450,000		450,000	(450,000)				34
35	Rent-Equipment & Vehicles			10,243	10,243		10,243	17,521	27,764			35
36	Other (specify):*							20,436	20,436			36
37	**TOTAL Ownership**			533,858	533,858		533,858	29,000	562,858			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		152,304	328,895	481,199		481,199		481,199			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,220	83,220		83,220		83,220			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		152,304	412,115	564,419		564,419		564,419			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,492,789	610,421	2,808,562	5,911,772		5,911,772	418,282	6,330,054			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,705)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(188)	2		13
14	Non-Care Related Interest	(4,188)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(2,578)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,904)	27		24
25	Fund Raising, Advertising and Promotional	(20,790)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,353)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	469,635		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 469,635		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 418,282		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

THE LINCOLN HOME

ID# 0034678

Report Period Beginning: 01/01/2005

Ending: 12/31/2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE LINCOLN HOME **#** 0034678 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(188)	0	0	0	0	0	0	0	0	0	0	(188)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(188)	0	0	0	0	0	0	0	0	0	0	(188)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	656,695	0	0	0	0	0	0	0	0	656,695	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	(299,010)	0	0	0	0	0	0	0	0	(299,010)	19
20	Fees, Subscriptions & Promotions	(23,368)	0	637	0	0	0	0	0	0	0	0	(22,731)	20
21	Clerical & General Office Expenses	0	0	15,774	0	0	0	0	0	0	0	0	15,774	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	965	0	0	0	0	0	0	0	0	965	26
27	Other (specify):*	(1,904)	0	39,681	0	0	0	0	0	0	0	0	37,777	27
28	**TOTAL General Administration**	(25,272)	0	414,742	0	0	0	0	0	0	0	0	389,470	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(25,460)	0	414,742	0	0	0	0	0	0	0	0	389,282	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE LINCOLN HOME # 0034678 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(21,705)	231,391	0	0	0	0	0	0	0	0	0	209,686	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(4,188)	235,545	0	0	0	0	0	0	0	0	0	231,357	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(450,000)	0	0	0	0	0	0	0	0	0	(450,000)	34
35	Rent-Equipment & Vehicles	0	0	17,521	0	0	0	0	0	0	0	0	17,521	35
36	Other (specify):*	0	0	20,436	0	0	0	0	0	0	0	0	20,436	36
37	**TOTAL Ownership**	(25,893)	16,936	37,957	0	0	0	0	0	0	0	0	29,000	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(51,353)	16,936	452,699	0	0	0	0	0	0	0	0	418,282	45

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				WEISS MGMT.		MGMT/
				GROUP, INC.	SKOKIE	CLERICAL
SEE ATTACHED SCHEDULE				LINCOLN		
				ASSOC., LTD.	SKOKIE	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 450,000	LINCOLN ASSOCIATES, LTD.		$	$ (450,000)	1
2	V	30	DEPRECIATION		" " "		231,391	231,391	2
3	V	32	INTEREST EXPENSE		" " "		235,545	235,545	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 450,000			$ 466,936	$ * 16,936	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 360,000	WEISS MANAGEMENT GROUP, INC.		$	$ (360,000)	15
16	V	19	BOOKKEEPING/ADMINIST.SERV	300,000	" " " "			(300,000)	16
17	V	35	EQUIPMENT RENT		" " " "		17,521	17,521	17
18	V	27	EMPLOYEE BENEFITS		" " " "		39,681	39,681	18
19	V	19	PROFESSIONAL FEES		" " " "		990	990	19
20	V	20	DUES, FEES, SUBSCRIPTIONS		" " " "		637	637	20
21	V	21	TOTAL OFFICE		" " " "		15,774	15,774	21
22	V	36	OFFICE RENT		" " " "		20,436	20,436	22
23	V	26	INSURANCE		" " " "		965	965	23
24	V	17	OFFICER SALARIES		" " " "		1,016,695	1,016,695	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 660,000			$ 1,112,699	$ * 452,699	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6			SEE ATTACHED SCHEDULE								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WEISS MANAGEMENT GROUP, INC
Street Address: 3856 OAKTON STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 933-9200
Fax Number: (847) 933-9765

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	35	EQUIPMENT RENT	DIRECT COST	1	1	$ 17,521	$	1	$ 17,521	1
2	27	EMPLOYEE BENEFITS	DIRECT COST	1	1	39,681		1	39,681	2
3	19	PROFESSIONAL FEES	DIRECT COST	1	1	990		1	990	3
4	20	DUES, FEES, SUBSCRIPTIONS	DIRECT COST	1	1	637		1	637	4
5	21	TOTAL OFFICE	DIRECT COST	1	1	15,774		1	15,774	5
6	36	OFFICE RENT	DIRECT COST	1	1	20,436		1	20,436	6
7	26	INSURANCE	DIRECT COST	1	1	965		1	965	7
8	17	OFFICER SALARIES	DIRECT COST	1	1	1,016,695	1,016,695	1	1,016,695	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,112,699	$ 1,016,695		$ 1,112,699	25

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 2/31/2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WEISS MANAGEMENT GROUP, INC
Street Address: 3856 OAKTON STREET
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Fax Number: (847) 933-9765

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: THE LINCOLN ASSOCIATION, LLC						$	$			$	1
2	CAMBRIDGE REALTY		X	MORTGAGE	$31,065.72	04/04	4,528,900	4,448,394	04/39	5.1400	229,815	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER LOAN		120,243	95,387			5,730	3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL	X		WORKING CAPITAL	DEMAND					PRIME+	499	6
7	WELLS FARGO BANK		X	AUTO FINANCE	$965.19	05/05	41,500	38,608		5.3900	800	7
8												8
9	TOTAL Facility Related				$32,030.91		$ 4,690,643	$ 4,582,389			$ 236,844	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,690,643	$ 4,582,389			$ 236,844	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number THE LINCOLN HOME # 0034678 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	29,733	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	37,967	2
3. Under or (over) accrual (line 2 minus line 1).	$	8,234	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	37,967	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	46,201	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	23,244	8
2001	24,488	9
2002	25,689	10
2003	29,752	11
2004	37,967	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 100% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2004 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE LINCOLN HOME COUNTY SINCLAIR

FACILITY IDPH LICENSE NUMBER 0034678

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-20.0-210-028	NURSING HOME	$ 233.90	$ 233.90
2.	08-20.0-210-029	NURSING HOME	$ 37,733.24	$ 37,733.24
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,967.14	$ 37,967.14

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,241 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 148,649	1
2	PARKING LOT		2005	50,000	2
3	TOTALS			$ 198,649	3

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	152		1988		$ 2,011,351	$ 63,852	31.5	$ 63,852	$	$ 1,078,577	4
5			2003		1,249,221	45,426	27.5	45,426		111,672	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1990	11,158	354	31.5	354		5,404	9
10	VARIOUS			1993	6,676	171	39	171		2,924	10
11	VARIOUS			1994	7,797	200	39	200		3,258	11
12	VARIOUS			1995	13,072	335	39	335		4,582	12
13	CARPET			1996	907	23	39	23		259	13
14	BILLBOARD			1996	900	23	39	23		262	14
15	SMOKE DETECTORS			1996	602	15	39	15		175	15
16	PARKING LOT			1996	8,006	205	39	205		2,435	16
17	AWNING			1996	905	23	39	23		277	17
18	CARPETING			1996	1,512	39	39	39		482	18
19	DOOR LOCKS			1997	2,100	54	39	54		544	19
20	WALL PAPER			1997	2,012	52	39	52		534	20
21	HANDRAIL			1997	3,217	83	39	83		776	21
22	FIRE ALARM SYSTEM			1998	11,636	298	39	298		2,377	22
23	WALLPAPER & HANDRAILS FOR NURSING STATION			1998	9,227	236	39	236		1,889	23
24	PAINTING/WALLPAPERING			1998	2,988	77	39	77		614	24
25	REPLACE PVC PIPE IN BASEMENT			1998	1,074	28	39	28		223	25
26	WALLPAPER, HANDRAILS, CRASHRAILS, CORNER GUARD			1999	6,144	158	39	158		716	26
27	INSTALLED A NEW DURO-LAST ROOF			1999	56,400	1,446	39	1,446		6,502	27
28	WALLPAPER			2000	14,896	382	39	382		2,655	28
29	SEWER LINE REPAIR			2000	11,743	301	39	301		1,649	29
30	AIR CONDITIONING UNITS			2000	8,848	227	39	227		1,243	30
31	CONDENSING UNIT ON FREEZER			2000	2,693	69	39	69		381	31
32	NEW NURSES STATION			2000	20,379	522	39	522		2,881	32
33	FIRE ALARM SYSTEM			2000	1,826	47	39	47		259	33
34	HOT WATER SYSTEM			2000	3,849	99	20	99		1,559	34
35	TILED FLOORS			2000	54,185	1,389	39	1,389		7,649	35
36	REMODELING OF BATHROOMS			2000	18,490	474	39	474		2,605	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	INSTALLED A/C UNITS FOR RESIDENT ROOMS	2000	$ 13,369	$ 726	20	$ 668	$ (58)	$ 5,998	37
38	WALLPAPERING, FLOORING,CARPENTING	2001	35,921	1,306	27.5	1,306		5,878	38
39	ROOF	2001	47,500	1,727	27.5	1,727		7,772	39
40	AIR CONDITIONERS,HEATERS, SPEAKERS	2001	9,154	334	27.5	334		1,502	40
41	ELECTRICAL WORK	2001	12,200	444	27.5	444		1,998	41
42	RECEPTION STATION	2001	11,356	413	27.5	413		1,858	42
43	WINDOW TREATMENTS, CUBICLE TRACK,DOORS	2001	54,533	1,983	27.5	1,983		8,923	43
44	EXTENSIVE WORK	2001	37,603	1,366	27.5	1,366		6,148	44
45	RESIDENT ROOMS-PAINTING, CLOSET, CORRID. DOORS	2002	31,159	2,346	20	1,558	(788)	6,232	45
46	RENOVATIONS TO THE SHOWER & STORAGE ROOM	2002	6,853	249	27.5	249		924	46
47	INSTALLATION OF THE NEW GENERATOR SET CONTROL	2002	17,036	619	27.5	619		2,296	47
48	INSTALL STEP RAILS FOR SIDEWALK AREA, FRONT ENTI	2002	7,245	263	27.5	263		975	48
49	LANDSCAPING	2004	7,759	1,551	15	517	(1,034)	711	49
50	REPLACEMENT WINDOWS	2004	32,853	6,571	20	1,643	(4,928)	3,286	50
51	INSTALL CONCRETE DUMSTER PAD AND DRIVE	2004	6,270	1,254	20	314	(940)	628	51
52	REMODELING SHOWER ROOM-FLOOR &WALL CERAMIC	2004	105,250	21,050	20	5,263	(15,787)	10,526	52
53	WALL AIR CONDITIONS	2005	3,190	53	27.5	53		53	53
54	FLOORING, WALLCOVERING-2 RESTROOMS	2005	2,528	42	27.5	42		42	54
55	FURNISH AND INSTALL FIRE RATED DOORS & FRAMES	2005	30,429	508	27.5	508		508	55
56	EXCAVATING AND POURING CONCRETE SIDEWALKS	2005	9,450	157	27.5	157		157	56
57	INSTALL RAILS, REPLACEMENT WINDOWS	2005	8,406	140	27.5	140		140	57
58	INSTALL ALARM SYSTEM	2005	39,496	658	27.5	658		658	58
59	NURSE CALL SYSTEM	2005	18,665	311	27.5	311		311	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,092,039	$ 160,679		$ 137,144	$ (23,535)	$ 1,312,887	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 97,033	$ 13,269	$ 17,364	$ 4,095	3-10	$ 73,311	71
72	Current Year Purchases	29,213	4,451	2,186	(2,265)	5-10	2,186	72
73	Fully Depreciated Assets	15,647					15,647	73
74	RELATED PARTY		70,807	70,807				74
75	TOTALS	$ 141,893	$ 88,527	$ 90,357	$ 1,830		$ 91,144	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	2005 FORD ECONOLINE	2005	$ 41,500	$ 8,300	$ 8,300	$	5	$ 8,300	76
77										77
78										78
79										79
80	TOTALS			$ 41,500	$ 8,300	$ 8,300	$		$ 8,300	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,474,081	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 257,506	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 235,801	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (21,705)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,412,331	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 6,045 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 CHEVY VAN	$ 815.00	$ 4,198	17
18					18
19					19
20					20
21	TOTAL		$ 815.00	$ 4,198	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 129,214	$		$ 129,214	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			25,315			25,315	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			174,366			174,366	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				108,581		108,581	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	RADIOLOGY, LAB	39-2					22,314		22,314	
	Other (specify): MED SUPPLIES	39-2					21,409		21,409	13
14	TOTAL			$		$ 328,895	$ 152,304		$ 481,199	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number THE LINCOLN HOME **#** 0034678 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 79,754	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,041,226		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	18,610		6
7	Other Prepaid Expenses	4,029		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): REAL ESTATE ESCROW	10,826		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,154,445	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	15,840		15
16	Equipment, at Historical Cost	173,272		16
17	Accumulated Depreciation (book methods)	(108,059)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 81,053	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,235,498	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 396,060	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	648,224		29
30	Accrued Salaries Payable	75,172		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,154		31
32	Accrued Real Estate Taxes(Sch.IX-B)	37,967		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,168,577	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,168,577	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 66,921	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,235,498	$	48

***(See instructions.)**

Facility Name & ID Number THE LINCOLN HOME # 0034678 **Report Period Beginning:** 01/01/2005 **Ending:** 12/31/2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 154,070	1
2	Restatements (describe):		2
3	ROUNDING	(1)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 154,069	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(87,148)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (87,148)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 66,921	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,629,692	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,629,692	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	190,744	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 190,744	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,188	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,188	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,824,624	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	970,757	31
32	Health Care	1,940,871	32
33	General Administration	1,901,867	33
	B. Capital Expense		
34	Ownership	533,858	34
	C. Ancillary Expense		
35	Special Cost Centers	481,199	35
36	Provider Participation Fee	83,220	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,911,772	40
41	**Income before Income Taxes (line 30 minus line 40)****	(87,148)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (87,148)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,127	2,127	$ 62,415	$ 29.34	1
2	Assistant Director of Nursing	4,171	4,247	81,873	19.28	2
3	Registered Nurses	6,535	6,896	149,743	21.71	3
4	Licensed Practical Nurses	25,443	26,743	471,262	17.62	4
5	CNAs & Orderlies	80,524	83,318	765,020	9.18	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,968	2,080	29,994	14.42	9
10	Activity Assistants	4,784	4,936	36,806	7.46	10
11	Social Service Workers	4,313	4,600	51,749	11.25	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	27,040	13.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	22,855	23,576	169,970	7.21	15
16	Dishwashers					16
17	Maintenance Workers	5,124	5,333	78,567	14.73	17
18	Housekeepers	21,877	23,155	175,514	7.58	18
19	Laundry	8,023	8,263	54,499	6.60	19
20	Administrator	2,160	2,339	77,268	33.03	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,939	12,676	159,557	12.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) SEE ATTACHED	5,766	6,260	101,512	16.22	33
34	TOTAL (lines 1 - 33)	209,689	218,629	$ 2,492,789 *	$ 11.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 12,078	1-3	35
36	Medical Director	O	37,000	9-3	36
37	Medical Records Consultant	N	4,500	10-3	37
38	Nurse Consultant	T	10,131	10-3	38
39	Pharmacist Consultant	H	2,736	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	3,042	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 69,487		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses	N/A	0	10-3	51
52	Certified Nurse Assistants/Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JESSICA FRITZ	ADMIN	0	$ 46,114
WOLFGANG VOLZ	ADMIN	0	31,154
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,268

B. Administrative - Other

Description	Amount
WEISS MANAGEMENT GROUP-MANAGEMENT FEES	$ 360,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 360,000

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		496,306
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 496,306

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 99,201
Unemployment Compensation Insurance	82,233
FICA Taxes	189,970
Employee Health Insurance	116,683
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	6,946
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 495,033

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	33,867
Health Care Worker Background Check	2,370
(Indicate # of checks performed 169)	
MARKETING/ADV/PROMO	20,790
TRUST/FRANCHISE/CONTRIB/ETC	2,578
LICENSES & PERMITS	1,330
DUES & SUBSCRIPTIONS	6,531
MGMT CO ALLOCATION	637
TRUST/FRANCHISE/CONTRIB/ETC	(2,578)
Less: Public Relations Expense	(0)
Non-allowable advertising	(20,790)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 44,735

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	10,094
Seminar Expense	3,556
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,650

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	PAINT/DECORATING		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number THE LINCOLN HOME # 0034678 Report Period Beginning: 01/01/2005 Ending: 12/31/2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $6056**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **YES** If YES, have these costs
been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
during this cost report period. $ **83,220**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees